TUFTS Health Plan
Medicare Preferred

Group Retiree HMO Election Form

DATE STAMP

1. Personal Information

Last Name _____ First Name _____ Middle Initial _____

Birth Date _____ Sex (M/F) ____ Primary Language _____ Social Security # ____ - ___ - _____

Permanent Address _____ City _____ State _____ Zip Code _____

County _____ Home phone number _____ Effective Date of Coverage _____

Mailing Address (if different) _____ City _____ State _____ Zip Code _____

Your (or spouse's) Former Employer's Name _____ Group # _____

Person to contact in case of emergency _____ Phone # _____ Relationship _____

Please fill in these blanks so they look the same as what is on your Medicare card. You need to fill this out, or you can attach a copy of your Medicare card, or your Letter of Verification from the Social Security Administration or Railroad Retirement Board. We cannot call this election form "finished" until you have given us this information.

Medicare Health Insurance
Social Security Act

Name of Beneficiary: _____

Medicare Claim Number — Sex

___ - _____ - _____ ___

Is Entitled To — Effective Date

___ Hospital Insurance (Part A) _____

___ Medical Insurance (Part B) _____

2. Plan information

Name of chosen Primary Care Physician (PCP) _____

Are you a current patient of this PCP? ☐ YES ☐ NO

3. Additional information

1. Do you have End State Renal Disease (ESRD)? ESRD is permanent kidney failure and requires regular kidney dialysis or a transplant to stay alive. ☐ YES ☐ NO

NOTE: If you have ESRD, you cannot enroll in this plan unless you are already enrolled in Tufts Health Plan as a commercial member and will soon be eligible for Medicare Part A and Part B, or you were affected by the non-renewal of another Medicare Advantage plan after December 31, 1998. If you do not need regular dialysis any more, or have had a successful kidney transplant, please attach a note or records from your doctor showing you don't need dialysis or have had a successful kidney transplant and check "No".

Your answer to the following questions will <u>not</u> keep you from enrolling in Tufts Medicare Preferred HMO.

2. Are you a resident in an institution (e.g., skilled nursing facility, rehabilitation hospital)? ☐ YES ☐ NO

   If yes, Name of Institution _____

   Address of Institution (number and street) _____

   Phone number of Institution _____ Your Date of Admission into Institution _____

3. Do you receive Medicaid benefits? ☐ YES ☐ NO

   If yes, Medicaid Number _____

4. Do you, on your own or through your spouse, have other drug or medical coverage such as private insurance, Workers Compensation, VA benefits, or State pharmaceutical assistance? ☐ YES ☐ NO

   If yes, what do you have? _____

   Provide the name of your insurance or assistance _____

5. Do you, or your spouse work? ☐ YES ☐ NO
6. Are you currently a Tufts Medicare Preferred HMO member? ☐ YES ☐ NO

Please Read and Sign Below:

By completing this enrollment application, I agree to the following:

Tufts Medicare Preferred HMO is a Medicare Advantage plan and I will need to keep my Parts A and B. I can only be in one Medicare Advantage plan at a time. It is my responsibility to inform you of any prescription drug coverage that I have or may get in the future. Enrollment in this plan is generally for the entire year. I may leave this plan only at certain times of the year, or under certain special circumstances, by sending a request to Tufts Medicare Preferred HMO or by calling 1-800-Medicare. TTY users should call 1-877-486-2048.

Tufts Medicare Preferred HMO serves a specific service area. If I move out of the area that Tufts Medicare Preferred HMO serves, I need to notify the plan so I can disenroll and find a new plan in my new area. Once I am a member of Tufts Medicare Preferred HMO, I have the right to appeal plan decisions about payment or services if I disagree. I will read the Member Handbook or Evidence of Coverage document from Tufts Medicare Preferred HMO when I receive it to know which rules I must follow in order to receive coverage with this Medicare Advantage plan.

I understand that beginning on the date Tufts Medicare Preferred HMO coverage begins, I must get all of my health care from Tufts Medicare Preferred HMO, with the exception of emergency or urgently needed services or out-of-area dialysis services. Medicare beneficiaries are generally not covered under Medicare while out of the county except for limited coverage in Canada and Mexico. Services authorized by Tufts Medicare Preferred HMO and other services contained in my Tufts Medicare Preferred HMO Evidence of Coverage document (also known as a member contract or subscriber agreement) will be covered. Without authorization, **NEITHER MEDICARE NOR TUFTS MEDICARE PREFERRED HMO WILL PAY FOR THE SERVICES.**

Release of Information: By joining this Medicare health plan, I acknowledge that the Medicare health plan will release my information to Medicare and other plans as is necessary for treatment, payment and health care operations. The information on this enrollment form is correct to the best of my knowledge. I understand that if I intentionally provide false information on this form, I will be disenrolled from the plan.

I understand that my signature (or the signature of the person authorized to act on behalf of the individual under the laws of the State where the individual resides) on this application means that I have read and understand the contents of this application. If signed by an authorized individual (as described above), this signature certifies that: 1) this person is authorized under State law to complete this enrollment and 2) documentation of this authority is available upon request by Tufts Medicare Preferred HMO or by Medicare.

Your Signature:	**Today's Date:**

If you are the authorized representative, you must provide the following information:

Name: _____

Address: _____

Phone Number: (_____) _____ – _____

Relationship to Enrollee _____

Office Use Only:

Name of staff member (if assisted in enrollment): _____

Plan ID #: _____

Effective Date of Coverage: _____

ICEP/IEP: _____ OEP: _____ AEP: _____ SEP (type): _____